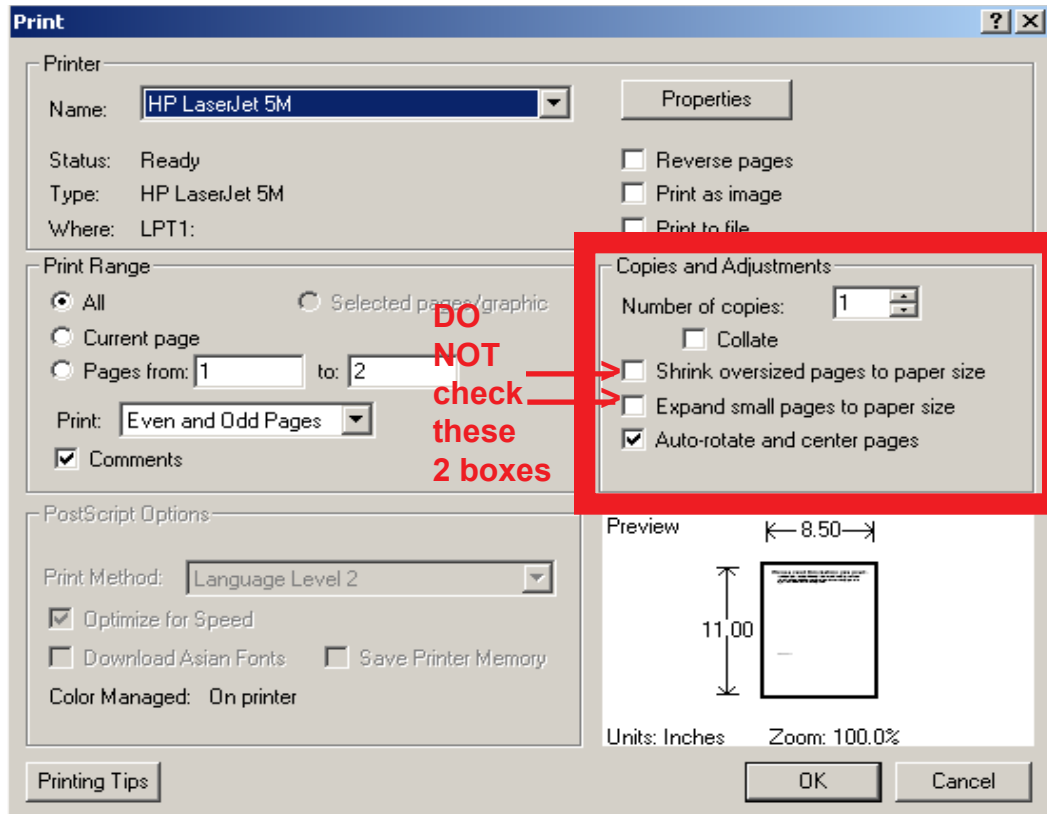


Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Expired Nursing Home Administrator Credential Application Packet

1. 661-033 Contents List/SSN Information/Deposit Slip 2 pages
2. 661-143 General Instructions—Application for Expired Nursing Home Administrator Credential Activation 2 pages
3. 661-142 Application for Expired Nursing Home Administrator Credential Activation 2 pages

B. Important Social Security Number Information:

- * Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
- * Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.



Cut along this line and return the form below with your completed application and fees.



Nursing Home Administrator (Expired)

DEPOSIT SLIP

NAME (Please Print)

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

DATE

Please note amount enclosed, and return
with your application.

\$

- ☐ Check
☐ Money Order

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Health Professions Quality Assurance
Board of Nursing Home Administrators
P.O. Box 1099
Olympia, WA 98507-1099

Application For Expired Nursing Home Administrator Credential Activation General Instructions

When your application for expired credential activation is received by the Department of Health, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process. This is the only notice you will receive while your application is pending. Applicants are discouraged from calling to check on the status of an application until receipt of this acknowledgment. Your cooperation is requested to permit program staff to prepare your file and re-activate your license at the earliest possible time.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ Pay \$145.00 Late Penalty Fee. **(All fees are non-refundable)**
- ☐ Pay \$250.00 Current Renewal Fee. **(All fees are non-refundable)**
- ☐ Pay \$147.50 Expired Credential Reissuance Fee. **(All fees are non-refundable)**

Total fees due: \$542.50 made payable by check or money order to The Department of Health

- ☐ **Box #1 Demographic Information.**

Name: Give your current name with middle initial.

Residential Address: Identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current telephone number where you may be reached during normal business hours.

Social Security Number: Required for license under 42 USC 666 and Chapter 26.23 RCW.

Additional Data: This information is required to update the Department's database, and confirm information from your initial application.

- ☐ **Box #2 Previous Credentialing.** List **all** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach a separate piece of paper.
- ☐ **Box #3 AIDS Education and Training Attestation.** Required by WAC 246-12-040.
- ☐ **Box #4 Criminal and Disciplinary Action Attestation.** Required by WAC 246-12-040. The Department does criminal background checks on all applicants.
- ☐ **Box #5 Continuing Education Attestation.** Required by WAC 246-12-040.
- ☐ **Box #6 Applicant's Attestation.** Required to be signed and dated in order to process the application.

Please mail application to: Department of Health
Board of Nursing Home Administrators
PO Box 1099
Olympia, WA 98507-1099

For licenses expired more than one year but less than five years:

- Submit documentation of completion of 36 hours of continuing education for the two year period immediately proceeding your request for reactivation.
- Continuing education courses must meet the conditions established in WAC 246-843-130.

For licenses expired five years or more:

- Submit documentation of completion of 36 hours of continuing education for the two-year period immediately proceeding your request for reactivation.
- Continuing education courses must meet the conditions established in WAC 246-843-130.
- Submit verification of active practice in another jurisdiction or successfully complete the current licensing examination.



Health Professions Quality Assurance
Board of Nursing Home Administrators
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY

<input type="checkbox"/> Late Renewal Penalty Fee	_____
<input type="checkbox"/> Current Renewal Fee	_____
<input type="checkbox"/> Substance Abuse Monitoring	N/A
<input type="checkbox"/> Expired Credential Reissuance Fee	_____
Total	_____

Credential #

Application For Nursing Home Administrator Expired Credential Activation

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE NAME OR INITIAL

RESIDENTIAL ADDRESS

CITY STATE ZIP COUNTY

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS HOURS.**) SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

()

GENDER BIRTHDATE (MO/DAY/YEAR) PLACE OF BIRTH (CITY/STATE)

☐ Female ☐ Male

/ /

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list other name(s):

2. Previous Credentialing (Since Last Being Credentialed in Washington State)

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. (Attach additional 8 1/2 x 11 sheets if necessary.)

STATE / JURISDICTION	PROFESSION	LICENSE			METHOD OF CREDENTIALING	CURRENTLY IN FORCE
		TYPE	YEAR ISSUED	NUMBER		
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes

3. AIDS Education And Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

4. Criminal and Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

The Department does criminal background checks on all applicants.

APPLICANT'S INITIALS

5. Continuing Education/Continuing Competency Attestation

I certify that I have met the continuing education (CE) requirement for the past two years. **I am enclosing documentation on all courses attended that accumulate to 36 hours of approved CE.**

APPLICANT'S INITIALS

6. Applicant's Attestation

I, _____, certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

DATE

Official Use Only
Washington State Records Center